

Name: _____ Date of Birth: _____

Diagnosis: _____

Allergies: _____

Medications: _____

Today's Date: _____ Form Completed By: _____

Please answer the following questions about your health and development so we can help with your needs.
(YOU always refers to the YOUNG PERSON)

Staff Only	Staying Healthy	YES	SOME-TIMES	NO
F/U	Medical Home: _____			
	1. Do you have a medical home (family doctor or clinic) that you go to when you are sick or need a check-up?			
	2. Do you have regular check-ups with your medical home provider?			
	3. Are you happy with your weight?			
	4. Do you exercise three times a week or more?			
	5. Do you brush your teeth at least daily?			
	6. Do you have a check-up with a dentist every year?			
	7. Do you have a soft formed bowel movement on a regular basis? (usually every other day)			
	8. Do you regularly use a seat belt?			
	9. Do you understand the changes that are happening to your body?			
	10. Do you understand the dangers of smoking, drinking, and using drugs?			

Name: _____

ID #: _____

Staff Only F/U	Managing Your Own Healthcare	YES	SOME- TIMES	NO
	Drugstore: _____			
	11. Can you describe your health problem?			
	12. Can you explain how your health problem affects your daily life?			
	13. Do you feel that your identified needs are being met?			
	14. Are you learning when, how much, and why you take medications? (prescription and over-the-counter, like Tylenol)			
	15. Are you beginning to be responsible for taking your own medications?			
	16. Are you learning the side effects of your medications?			
	17. Are you able to get the medications, supplies, and/or equipment you need?			
	18. Is your family able to pay for your dental needs?			
	19. Do you know when you will be too old to keep seeing your current healthcare providers?			
Staff Only F/U	Being Independent	YES	SOME- TIMES	NO
	20. Are you learning to take care of your personal needs?			
	21. Are you learning to do things around the house? (laundry, meal preparation)			
	22. Do you help around the house? (chores, babysitting)			
	23. Are you satisfied with how you are able to get around?			

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Staff Only	Emotional Health	YES	SOME-TIMES	NO
F/U				
	24. Can you describe things that you are good at?			
	25. Do you know someone that you can talk with when you feel sad, nervous, or things aren't going well?			
	26. Do you have friends that you spend time with at least once a week?			
	27. Do you spend time doing things with your family at least once a week?			
Staff Only	School & Work	YES	SOME-TIMES	NO
F/U	School: _____ Grade: _____			
	28. Do you go to school regularly?			
	29. Do you think that your schoolwork is at the right level for you?			
	30. Are you doing well in school?			
	31. Does your school give you the necessary time and space to take care of your health needs? (like taking medications or having extra room for equipment)			
	32. Do you take part in planning your education? (like picking your classes)			
	33. Does someone at your school talk with you about your plans for the future?			
	34. Do you have a volunteer or paying job? (like babysitting, yard work, tutoring other kids)			

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Staff Only F/U	Commission Satisfaction	YES	SOME- TIMES	NO
	35. Are you pleased with the care you receive at the Commission?			
What would you like to see done differently:				

Check All Information You Would Like to Have:

- | | | | |
|---|--|---|---|
| <input type="radio"/> Assistance Programs | <input type="radio"/> Sexual Development | <input type="radio"/> School | <input type="radio"/> Scholarships |
| <input type="radio"/> Medicaid | <input type="radio"/> Counseling | <input type="radio"/> Careers | <input type="radio"/> Colleges |
| <input type="radio"/> Social Security | <input type="radio"/> Transportation | <input type="radio"/> Independent
Living | <input type="radio"/> Vocational Rehabilitation |

Your Comments:

STAFF USE ONLY: _____

Reviewed By:

Initials	Signature	Date